INSTRUCTIONS FOR PLACING YOUR ORDER

Contact your doctor to write a new prescription for a three-month supply with authorized refills for up to one year.

OPTION 1: MAIL Your Order

1. Complete the New Patient Mail Order Form enclosed.
2. Attach your prescriptions to the order form.
3. Mail the New Patient Mail Order Form and your prescriptions to:

Express Scripts, Inc.
Mail Pharmacy Service
PO Box 66773
St. Louis, MO 63166-6773

Client ID:
ANCHOR/GAB

OPTION 2: FAX Your Order

1. Complete the New Patient Mail Order Form enclosed.
2. Ask your doctor to fax the New Patient Order Form and your written prescriptions to:

Fax Number: 1-800-521-5779

Legally, we can only accept a faxed prescription from your DOCTOR'S OFFICE. Faxes sent from other locations (such as your home or workplace) will not be accepted.

DOCTOR NOTE: We cannot accept Schedule II controlled substances by fax. All prescriptions for these medications must be mailed.

NEW PATIENT MAIL ORDER FORM

PLEASE PRINT IN **ALL CAPITAL LETTERS** USING **BLACK INK**.

IF THERE ARE MORE THAN 3 FAMILY MEMBERS, WRITE THE INFORMATION ON A SEPARATE PIECE OF PAPER.

1. PERSONAL INFORMATION

CARDHOLDER

ID NUMBER ___

FIRST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ M.I. ___

LAST NAME ___

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) ___ ASPIRIN (03) ___ CODEINE (04) ___ SULFA (15) ___

TETRACYCLINE (07) ___ ERYTHROMYCIN (09) ___ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) ___ BIRTH DATE ___ ___ – ___ ___ – ___ ___ (M M – D D – Y Y) GENDER ___

PLEASE PROVIDE A STREET ADDRESS. CERTAIN MEDICATIONS CANNOT BE DELIVERED TO A POST OFFICE BOX.

MAILING ADDRESS ___

CITY ___

STATE ___ ___ **ZIP CODE** ___ ___ ___ ___ ___ – ___ ___ ___ ___

Client ID:
ANCHOR/GAB

PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

PHYSICIAN LAST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PHYSICIAN PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

FAMILY MEMBER 1

FIRST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ M.I. ___

LAST NAME ___

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) ___ ASPIRIN (03) ___ CODEINE (04) ___ SULFA (15) ___

TETRACYCLINE (07) ___ ERYTHROMYCIN (09) ___ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) ___ BIRTH DATE ___ ___ – ___ ___ – ___ ___ (M M – D D – Y Y) GENDER ___

PHYSICIAN LAST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PHYSICIAN PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

FAMILY MEMBER 2

FIRST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ M.I. ___

LAST NAME ___

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) ___ ASPIRIN (03) ___ CODEINE (04) ___ SULFA (15) ___

TETRACYCLINE (07) ___ ERYTHROMYCIN (09) ___ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) ___ BIRTH DATE ___ ___ – ___ ___ – ___ ___ (M M – D D – Y Y) GENDER ___

PHYSICIAN LAST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PHYSICIAN PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

NEW PATIENT MAIL ORDER FORM

FAMILY MEMBER 3

FIRST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ M.I. ___

LAST NAME ___

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) ___ ASPIRIN (03) ___ CODEINE (04) ___ SULFA (15) ___

TETRACYCLINE (07) ___ ERYTHROMYCIN (09) ___ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) ___ BIRTH DATE ___ ___ – ___ ___ – ___ ___ GENDER ___
M M D D Y Y

PHYSICIAN LAST NAME ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PHYSICIAN PHONE # ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

2. PAYMENT METHOD

PLEASE INCLUDE PAYMENT WITH YOUR ORDER. **DO NOT SEND CASH**. STANDARD DELIVERY OF YOUR ORDER IS **FREE** AND WILL ARRIVE WITHIN 14 DAYS FROM THE DATE WE RECEIVE YOUR ORDER.

NOTE: YOUR CREDIT CARD WILL BE CHARGED ACCORDING TO YOUR PRESCRIPTION PLAN. ALL FUTURE ORDERS WILL BE CHARGED TO THIS CREDIT CARD, UNLESS PAYMENT (CHECK) ACCOMPANIES THE ORDER.

CREDIT CARD # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

CARDHOLDER NAME _____ **EXPIRATION DATE** ___ ___ – ___ ___
PLEASE PRINT NAME AS IT APPEARS ON CREDIT CARD M M Y Y

Client ID:
ANCHOR/GAB

_____
AUTHORIZED SIGNATURE

NOTE: IF PAYING BY CHECK OR MONEY ORDER, PLEASE REFER TO YOUR PRESCRIPTION PLAN MATERIALS FOR PRESCRIPTION COPAY.

CHECK/MONEY ORDER ___ **AMOUNT ENCLOSED $** ___ ___ ___ ___ . ___ ___

3. SIGNATURE REQUIRED

PLEASE CHECK ANY OF THE TWO OPTIONS (IF APPLICABLE) AND SIGN THE FOLLOWING STATEMENT.

___ I WOULD LIKE MY PRESCRIPTIONS DISPENSED WITH NON-CHILD RESISTANT (EASY OPEN) CAPS.

___ I REQUEST THAT THIS AND FUTURE ORDERS BE SHIPPED "SIGNATURE REQUIRED" FOR AN ADDITIONAL CHARGE.

I CERTIFY THAT ALL THE INFORMATION ON THIS FORM IS CORRECT, INCLUDING ANY SELECTIONS MADE FOR SENDING MY ORDER "SIGNATURE REQUIRED" OR FOR NON-CHILD RESISTANT (EASY OPEN) CAPS. I PERMIT EXPRESS SCRIPTS INC. TO RELEASE ALL INFORMATION ON THIS FORM CONCERNING PRESCRIPTION ORDERS TO MY PLAN SPONSOR, ADMINISTRATOR OR HEALTH PLAN FOR THE PURPOSE OF PAYMENT, TREATMENT, OR HEALTH CARE OPERATIONS. _____
AUTHORIZED SIGNATURE

4. REVIEW YOUR PRESCRIPTION

TO AVOID DELAYS IN PROCESSING YOUR ORDER:

- **CHECK TO SEE IF THE PATIENT NAME, ADDRESS AND DATE OF BIRTH IS CLEARLY WRITTEN ON THE PRESCRIPTION.** IF NOT, PRINT THE PATIENT'S FULL NAME, ADDRESS, PHONE NUMBER AND DATE OF BIRTH ON THE BACK OF THE PRESCRIPTION.
- **CHECK TO SEE IF THE PHYSICIAN SIGNATURE IS LEGIBLE AND PHYSICIAN PHONE NUMBER IS PRINTED ON THE PRESCRIPTION.** IF NOT, PLEASE CIRCLE THE PHYSICIAN'S NAME ON THE PRESCRIPTION, OR PRINT THE PHYSICIAN NAME AND PHONE NUMBER, INCLUDING AREA CODE ON THE BACK OF THE PRESCRIPTION.

NOTE: WE WILL DISPENSE FDA APPROVED GENERIC MEDICATIONS WHEN ALLOWED BY YOUR PHYSICIAN, SUBJECT TO THE TERMS OUTLINED IN YOUR PLAN.

QUESTIONS ABOUT YOUR PHARMACY BENEFIT?
CALL THE CUSTOMER SERVICE NUMBER THAT WAS PROVIDED TO YOU.